EPARTMENT OF HEALTH AND HUMAN SERVICES
EALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96-011

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

O: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7-1-96

. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

. FEDERAL STATUTE/REGULATION CITATION:
42 U.S.C. 1396r-4; 42 CFR 447

7. FEDERAL BUDGET IMPACT: (in Thousands)
a. FFY 96 $ 912.92
b. FFY 97 $ 3,651.67

. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A(1)
Pages 4,35, 35a, 36, 37, 38, 38a, 38b
Exhibits 5,10,11,12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A(1)
Pages 4, 35-38a
Exhibits 5 and 10

10. SUBJECT OF AMENDMENT:
1. Acute Hospital Inpatient Disproportionate Share Adjustments
2. Acute Hospital Inpatient Payment System

1. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required Under 45 CFR 204.1

2. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

3. TYPED NAME:
Bruce M. Bullen

4. TITLE:
Commissioner

5. DATE SUBMITTED:
9/27/96

16. RETURN TO:
Bridget Landers
State Plan Coordinator
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

JUN 06 2001

REGIONAL OFFICIAL:

TYPED NAME:

TITLE:

8. REMARKS:

OFFICIAL
JUN 06 2001

FORM HCFA-179 (07-92)

Instructions on Back

INSTITUTIONAL STATE PLAN
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: Massachusetts
TN: 96-011

REIMBURSEMENT TYPE:

Inpatient hospital	x
Nursing facility	
ICF/MR	

PROPOSED EFFECTIVE DATES: July 1, 1996

A. *State Assurances and Findings. The State assures that it has made the following findings:*

1. *447.253(b)(1)(i) - The State pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.* x

2. *With respect to inpatient hospital services --*

   a. *447.253(b)(1)(ii)(A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.* x

   b. *447.253(b)(1)(ii)(B) - If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.* x

   If the answer is "not applicable," please indicate:

   _____ _____

   c. *447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.* x

3. *With respect to nursing facility services --*

   a. *447.253(b)(1)(iii)(A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR part 483 subpart B.* n/a

b. 447.253(b)(1)(iii)(B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) to provide licensed nurses on a 24-hour basis. n/a

c. 447.253(b)(1)(iii)(C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public. n/a

4. 447.253(b)(2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

a. 447.272(a) - Aggregate payments to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. x

b. 447.272(b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) -- when considered separately -- will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. x

If there are no State-operated facilities, please indicate "not applicable:" _____

c. 447.272(c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299. x

d. Section 1923(g) - DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act. x

B. State Assurances. The State makes the following additional assurances:

1. For hospitals --

a. 447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable) acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation. x

2. *For nursing facilities and ICFs/MR--*

   a. *447.253(d)(1) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984 but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.* n/a

   b. *447.253(d)(2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:*

   (i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

   (ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year. n/a

3. *447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.* x

4. *447.253(f) - The State requires the filing of uniform cost reports by each participating provider.* x

5. *447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers.* x

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6. 447.253(h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: June 28, 1996; August 10, 1996

If no date is shown, please explain: _____

7. 447.253(i) - The State pays for inpatient hospital and long-term care services using rates determined in accordance with the methods and standards specified in the approved State plan. x

C. Related Information

1. 447.255(a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Inpatient Acute Hospital

For hospitals: Include DSH payments in the estimated average rates. You may either combine hospital and DSH payments or show DSH separately. If including DSH payments in a combined rate, please initial that DSH payment are included. _____
Estimated average proposed payment rate as a result of this amendment: see attached
Average payment rate in effect for the immediately preceding rate period: see attached
Amount of change: see attached
Percentage of change: see attached

2. 447.255(b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis: no effect

(b) The type of care furnished: no effect

(c) The extent of provider participation: no effect

(d) For hospitals -- the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs: Title XIX payments to disproportionate share hospitals will increase by approximately $3.5 million annually

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OFFICIAL

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I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by _____ Date Sept. 25, 1996
Title: Manager of Acute Hospital Services
Division of Medical Assistance

Related Rate Attachment to Assurance and Finding Certification Statement

In accordance with 42 CFR 447.255, the Medicaid agency provides the following information on FY96 estimated average rates and the amount by which these have changed before and after the effective date of the State Plan Amendment.

Period	Estimated Acute Per Diem	Projected Annual Disproportionate Share Hospital Payments
4/6/96 – 6/30/96	$979.15	$416 M
7/1/96 – 9/30/96	$1,008.52	$416.9 M
Difference:	3.0%	0.2%

In accordance with 42 CFR 447.255, the Medicaid agency estimates that the change in estimated average rates will have no negative short-term or long-term effect on: the availability of services (both on a statewide and geographic basis); the type of care furnished; and the extent of provider participation. The Medicaid agency estimates that the degree to which hospital costs are covered will increase approximately $0.9 million in FY96 as a result of the Public Health Substance Abuse disproportionate share adjustment.

Outlier Day - Each day during which a recipient remains hospitalized at acute (non-psychiatric) status beyond twenty acute days during the same, single admission. AD days occurring within the period of hospitalization are not counted toward the outlier threshold as described in Section IV.2.A.8.

Pass-Through Costs - Organ acquisition and malpractice costs that are paid on a cost-reimbursement basis and are added to the hospital-specific standard payment amount.

Pediatric Specialty Hospital - An acute hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit - A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeds 0.20, unless located in a facility already designated as a specialty hospital.

Public Service Hospital - Any public acute hospital or any hospital operating pursuant to Chapter 147 of the Acts and Resolves of 1995, which has a private sector payor mix that constitutes less than twenty-five percent (25%) of its gross patient service revenue (GPSR) and where uncompensated care comprises more than twenty percent (20%) of its GPSR.

Rate Year (RY) - The period beginning October 1 and ending September 30. RY96 begins October 1, 1995 and ends September 30, 1996.

Recipient - A person determined by the Division to be eligible for medical assistance under the Medicaid program.

Sole Community Hospital - Any acute hospital classified as a sole community hospital by the U.S. Health Care Financing Administration's Medicare regulations.

Specialty Hospital - Any acute hospital which limits admissions to children or to patients under active diagnosis and treatment of eyes, ears, nose, and throat, or diagnosis and treatment of cancer and which qualifies as exempt from the Medicare prospective payment system regulations.

Transfer Patient - Any patient who meets any of the following criteria: 1) transferred between acute hospitals; 2) transferred between a distinct part psychiatric unit and a medical/surgical unit in an acute hospital; 3) transferred between a bed in a DMH Replacement Unit in an acute

a. Supplementary Essential NICU Services

Payment for essential NICU services, for hospitals that began operating and admitting NICU patients during rate year 1993, shall be made as an add-on to the hospital-specific SPAD rate described in Section IV.A.2. The add-on amount shall equal the Medicaid share of reasonable costs of the NICU unit (as submitted to and approved by the Division) divided by projected and approved FY93 total Medicaid discharges. The Medicaid share of NICU costs shall equal reasonable per discharge costs of the NICU unit multiplied by projected FY93 Medicaid NICU discharges. The hospital-specific NICU add-on was updated for inflation using factors of 3.01%, 2.80% and 3.16%.

b. Existing Essential NICU Services

Payment for capital costs associated with existing essential NICU services, where these capital costs were recognized in the FY92 RFA reimbursement methodology, shall be made as an add-on to the capital payment amount per discharge described in Section IV.A.5. The add-on amount shall equal: FY92 capital costs related to the NICU unit, divided by the hospital's total FY91 non-DPU days, and then multiplied by the hospital-specific non-DPU FY91 Medicaid average length of stay (see Section IV.A.5). The hospital-specific NICU add-on amount was updated for inflation using factors of 3.01%, 2.80% and 3.16%.

5. State-Owned Acute Teaching Hospitals

a. Subject to Section IV.2.B.5.b, effective July 1, 1996, the inpatient payment amount for state-owned acute teaching hospitals' acute non-psychiatric admissions shall be equal to the hospital's RY96 cost per discharge calculated as follows:

FY95 total hospital-specific inpatient non-psychiatric charges are multiplied by the hospital's inpatient non-psychiatric cost-to-charge ratio (calculated using FY95 RSC 403, Schedule II, column 10, line 100 minus column 10, line 82 for the total cost numerator and Schedule II, column 11, line 100 minus column 11, line 82 for the total charges denominator) to compute that facility's total inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the FY95 hospital-specific non-psychiatric Medicaid discharges to the FY95 total hospital non-psychiatric discharges to yield the Medicaid inpatient non-psychiatric cost. The Medicaid inpatient non-psychiatric cost is then divided by the number of FY95 Medicaid non-psychiatric discharges to calculate the Medicaid cost per discharge. This Medicaid cost per discharge is multiplied by the inflation rate of 3.16% to reflect inflation between RY95 and RY96.

b. Any payment amount in excess of amounts which would otherwise be due any state-owned teaching hospital pursuant to Sections IV.2.A.2-6 and 8-9 is subject to specific legislative appropriation.

C. Classification of Disproportionate Share Hospitals (DSHs) and Payment Adjustments

Medicaid will assist hospitals that carry a disproportionate financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment above the rate under the RFA contract to hospitals which qualify for such an adjustment under any one or more of the classifications listed below. Only hospitals that have an executed contract with the Division, pursuant to the RFA, are eligible for disproportionate share payments since the dollars are, in most cases, apportioned to the eligible group in relation to each other. Medicaid-participating hospitals may qualify for adjustments and may receive them at any time throughout the rate year. If a hospital's RFA contract is terminated, its adjustment shall be prorated for the portion of the rate year during which it had a contract with the Division. The remaining funds it would have received shall be apportioned to remaining eligible hospitals. The following describes how hospitals will qualify for each type of disproportionate share adjustment and the methodology for calculating those adjustments.

The Division has added the following requirements to be eligible for DSH payments, in accordance with recent changes to federal and state law. First, hospitals must have a Medicaid inpatient utilization rate of at least 1% to be eligible for any type of DSH payment, pursuant to recently amended regulations promulgated by the Division of Health Care Finance and Policy (DHCFP) and found at 114.1 CMR 36.13(10) (attached as ***Exhibit 5****). Second, the total amount of DSH payment adjustments awarded to any hospital shall not exceed the costs incurred during the year of furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and by uninsured patients ("unreimbursed costs").*

When a hospital applies to participate in Medicaid, its eligibility and the amount of its adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications. Therefore, some disproportionate share adjustments may require recalculation pursuant to DHCFP regulations set forth at 114.1 CMR 36.13(10). Hospitals will be informed if the adjustment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

To qualify for a DSH payment adjustment under any classification within Section III.C, a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. §1396r-4(d) or qualify for the exemption described at 42 U.S.C. §1396r-4(d)(2).

1. ***High Public Payor Hospitals: Sixty-Three Percent Hospitals (Total Funding: $11,700,000)***

The eligibility criteria and payment formula for this DSH classification are specified in DHCFP regulations at 114.1 CMR 36.13(10)(a) (attached as ***Exhibit 5****). For purposes of this classification only, the term "disproportionate share hospital" refers to any acute hospital that exhibits a payor mix where a minimum of sixty-three percent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payors and free care.*

2. ***Basic Federally Mandated Disproportionate Share Adjustment (Total Funding: $200,000)***

The eligibility criteria and payment formula for this DSH classification are described in DHCFP regulations at 114.1 CMR 36.13(10)(b) (attached as ***Exhibit 5****) and in accordance with the minimum requirements of 42 U.S.C. §1396r-4.*

3. ***Disproportionate Share Adjustment for Safety Net Providers***

A disproportionate share safety net adjustment factor for all eligible hospitals shall be determined.

This class of hospital was identified and included to ensure that those hospitals that provide the services most critical to the poor are reimbursed for their overload of free care so that they can continue to provide the services that we deem crucial to the provision of adequate health care.

a. Determination of Eligibility

The disproportionate share adjustment for safety net providers is an additional payment for all hospitals eligible for the basic federally-mandated disproportionate share adjustment pursuant to Section IV.2.C.2. above, which also meet the following additional criteria:

i. is a public hospital;
ii. has a volume of free care charges in FY93 that is at least 15% of total charges;
iii. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs, including persons with AIDS, trauma victims, high-risk neonates, and

indigent patients without access to other providers;

iv. *has completed an agreement with the Division of Medical Assistance for the federally-mandated disproportionate share adjustment for safety net providers.*

b. *Payment Methodology*

An additional adjustment shall be calculated for federally-mandated disproportionate share hospitals that are eligible for the safety net provider adjustment.

i. *This payment amount shall be reasonably related to the costs of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients.*

ii. *This payment adjustment shall be based on an agreement between the Division and the qualifying hospital. The Division shall make a disproportionate share payment adjustment to the qualifying hospital; provided that such payment shall be adjusted if necessary, to ensure that a qualifying hospital's total disproportionate share adjustment payments for a fiscal year under the State Plan do not exceed 100% of such hospital's total unreimbursed free care and unreimbursed Medicaid costs for the same fiscal year. Such unreimbursed costs shall be calculated by the Division using the best data available, as determined by the Division for the fiscal year.*

iii. *The payment of the safety net adjustment to a qualifying hospital in any rate year shall be contingent upon the continued availability of federal financing participation for such payments.*

4. *Uncompensated Care Disproportionate Share Adjustment*

Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in DHCFP regulations at 117 CMR 7.00 (attached as Exhibit 6). The payment amounts for eligible hospitals participating in the free care pool are determined and paid by

DHCFP in accordance with its regulations at 117 CMR 7.00.

5. Medical Security Unemployment Disproportionate Share Adjustment

Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low income unemployed individuals who are uninsured or covered only by a wholly state-financed program of medical assistance of the Department of Employment and Training (DET), in accordance with the regulations of the DET set forth at 117 CMR 9.00(attached as Exhibit 9). Eligible hospitals participating in the Medical Security plan are determined and paid on a quarterly basis by the DET in accordance with its regulations at 117 CMR 9.00 and its ISA with the Division.

The payment amount for each eligible hospital equals the hospital's cost-to-charge ratio calculated using Medicare cost principles, times the hospital's allowable charges for each eligible uninsured unemployed individual participating in the Medical Security direct service plan. Such payments shall be adjusted if necessary, to ensure that a qualifying hospital's total disproportionate share adjustment payments for a fiscal year under the State Plan do not exceed 100% of such hospital's total unreimbursed free care and unreimbursed Medicaid costs for the same fiscal year. Such unreimbursed costs shall be calculated by the Division using the best data available, as determined by the Division for the fiscal year.

6. Public Health Substance Abuse Disproportionate Share Adjustment

Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low-income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000 (attached as ***Exhibit 11****), and DPH's ISA with the Division of Medical Assistance (Division). The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 (attached as* ***Exhibit 12****) and DPH's ISA with the Division.*

The rate methodology used to develop payment amounts for substance abuse inpatient hospital disproportionate share payments is a per diem fee schedule established and approved by the Division of Health Care Finance and Policy for inpatient acute substance abuse treatment services. This per diem is an all-inclusive per diem incorporating all medically necessary routine and ancillary services provided. The per diem rate is based on the costs from the freestanding community inpatient substance abuse treatment setting. These free standing inpatient community costs used to calculate the fee for inpatient acute substance abuse services are substantially less than the actual hospital based costs for the same services.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

D. Treatment of Reimbursement for Recipients in the Hospital on the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis, reimbursement to participating hospitals for services provided to Medicaid recipients who are at acute inpatient status prior to October 1, 1995 and who remain at acute inpatient status on October 1, 1995 shall continue to be at the hospital's rates established prior to the RY96 RFA.

E. Upper Limit

Payment adjustments may be made for reasons relating to the Upper Limit if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA).

F. Future Rate Years

Adjustments may be made each rate year to update rates.

Attachment 4.19A (1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-11
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 5: 114.1 CMR 36.13(10)